DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Plans
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

Memorandum No: 04-90 MAA
Issued: December 30, 2004

For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Physician-Related Services: 2005 Changes and Additions to CPT® and HCPCS Codes, Policies, and Fee Schedule

Effective for dates of service on and after January 1, 2005, the Medical Assistance Administration (MAA) will:

- Begin using the Year 2005 Current Procedural Terminology (CPT)® and Healthcare Common Procedural Coding System (HCPCS) Level II code additions as discussed in this memorandum. Maximum allowable fees for the Year 2005 additions and 2005 Base Anesthesia Units (BAU) are also included.
- Update and clarify various policies and payment rates.

Overview

- The attached "January 2005 New Procedure Codes and Maximum Allowable Fees" reflect **only** the new 2005 BAU, CPT, and HCPCS codes.
- All procedure code maximum allowable fees and BAU not listed on the fee schedules or in this numbered memorandum remain at the July 1, 2004, amount.
- **Do not use** CPT and HCPCS codes that are deleted in the "Year 2005 CPT" book and the "Year 2005 HCPCS" book after December 31, 2004.

Maximum Allowable Fees and BAU

MAA used the following resources in determining the maximum allowable fees and BAU for the Year 2005 additions:

- Year 2005 Medicare Physician Fee Schedule Data Base (MPFSDB) relative value units;
- Year 2005 Washington State Medicare Laboratory Fee Schedule; and
- Current conversion factors.

☞ **Note:** Due to its licensing agreement with the American Medical Association regarding the use of CPT codes and descriptions, MAA publishes only the official brief descriptions for all codes. Please refer to your current CPT book for full descriptions.

Deleted CPT and HCPCS Modifiers

There are no deleted CPT or HCPCS modifiers for 2005.

New 2005 HCPCS Modifiers

Many new modifiers were added in the 2005 HCPCS book. MAA will accept all of these modifiers as informational only. Modifier descriptions may be viewed in the 2005 HCPCS book. MAA may require inclusion of some of the modifiers for payment purposes. MAA will notify providers in future memorandums when a modifier is required for payment purposes.

Deleted CPT and HCPCS Codes

The following codes have been deleted from the CPT and HCPCS books:

35161	79001	92589	0014T	Q0183
35162	79020	97601	0015T	S0115
35582	79030	97780	G0001	S0163
50559	79035	97781	G0292	S0165
50578	79100	0001T	J3245	S0830
50959	79400	0005T	J3395	S2113
50978	79420	0006T	J7618	
52347	79900	0007T	J7619	
78810	88180	0009T	J7621	
78990	91032	0012T	L0515	
79000	91033	0013T	Q0182	

Prior Authorization Update

As of January 1, 2005, the following new CPT and HCPCS codes require Prior Authorization (PA):

19296	32019	78815	0077T	0086T
19297	43644	78816	0078T	J7343
19298	43645	79005	0079T	J7344
27412	43845	79101	0080T	S2082
27415	52402	79445	0081T	S2083
29866	58356	93745	0082T	S2152
29867	76510	97605	0083T	J7343
31620	78814	97606	0085T	

* For details on MAA's prior authorization process, refer to the Authorization Section (Section I) of MAA's current *Physician-Related Services Billing Instructions*.

Radiology

Billing Clarification

- MAA ***does not*** reimburse radiologists for after-hours service procedure codes 99050-99054.

- MAA will no longer accept ICD-9-CM diagnosis code V72.5 (radiology exam, not otherwise classified) on radiology claims. Providers must use the appropriate medical ICD-9-CM diagnosis code that best describes the signs and/or symptoms or conditions found.

PET Scans

New CPT PET scan codes 78814 - 78816 require prior authorization. For details on MAA's prior authorization process, refer to the Authorization Section (Section I) of MAA's current *Physician-Related Services Billing Instructions*.

Contrast Material

MAA has set maximum allowable fees for the following contrast materials for nuclear medicine procedures:

HCPCS Code	Brief Description	January 1, 2005 Maximum Allowable Fee
A4642	Satumomab pendetide per dose	$1,440.50
A4643	High dose contrast MRI	66.65
A4644	Contrast 100-199 MGs iodine	0.65
A4645	Contrast 200-299 MGs iodine	0.81
A4646	Contrast 300-399 MGs iodine	0.94
A9500	Technetium TC 99m sestamibi	110.17
A9502	Technetium TC99M tetrofosmin	108.36
A9503	Technetium TC 99m medronate	30.10
A9504	Technetium TC 99m apcitide	430.00
A9505	Thallous chloride TL 201/mci	30.08
A9507	Indium/111 capromab pendetid ***(Requires PA)***	1,984.45
A9508	Iobenguane sulfate I-131	1,032.00
A9510	Technetium TC99m Disofenin	51.60
A9511	Technetium TC 99m depreotide	688.00
A9512	Technetiumtc-99 mpertechnetate	12.24
A9513	Technetium tc-99m mebrofenin	46.57
A9514	Technetium tc99mpyrophosphate	39.56
A9515	Technetium tc-99m pentetate	25.46
A9516	I-123 sodium iodide capsule	116.27
A9519	Technetiumtc-99mmacroag albu	16.34
A9520	Technetiumtc-99m sulfur clld	64.50
A9521	Technetiumtc-99m exametazine	268.75
A9522	Indium111ibritumomabtiuxetan ***(Requires PA)***	2,045.89
A9523	Yttrium-90 ibritumomabtiuxetan ***(Requires PA)***	18,603.16
A9533	I-131 tositumomab diagnostic ***(Requires PA)***	2,322.00
A9534	Strontium-89 chloride ***(Requires PA)***	20,124.00
A9600	Samarium sm153 lexidronamm	872.15
A9605	Samarium sm153 lexidronamm	923.37

Invoice must be attached to claim form for supplies over $50.00 if fee schedule states Acquisition Cost (A.C.)

For details on MAA's prior authorization process, refer to the Authorization Section (Section I) of MAA's current *Physician-Related Services Billing Instructions*.

Any covered HCPCS codes for contrast materials not listed above remain at the July 1, 2004 maximum allowable fee.

Consultations

All consultations or referred laboratory or radiology services must have a valid MAA provider ID number. Otherwise, input the referring physician's name in the appropriate box on the claim form (e.g., boxes 17 or 17a of a CMS-1500 form).

STAT Laboratory Changes

The new 2005 laboratory procedure codes may not be billed with an additional STAT charge (HCPCS code S3600).

Injectable Drug Updates

New Immunization Administration Codes

MAA will reimburse providers for the following new immunization administration codes:

CPT Code	Brief Description	1/1/05 Maximum Allowable Fee
90465	Immune admin 1 inj, <8 yrs	$11.11
90466	Immune admin addl inj, < 8 yrs	6.57
90467	Immune admin O or N < 8 yrs	5.00
90468	Immune admin O/N, addl < 8 y	3.00

Do not bill any of the above codes in combination with CPT codes 90471-90472. Reimbursement for immunization administration charges is limited to a maximum of two vaccines (e.g., one unit of 90465 and one unit of 90466; or one unit of 90467 and one unit of 90468).

Unlisted Drugs (J3490 and J9999)

This is a reminder that unlisted drug codes **must** always be billed with the following:

- NDC (National Drug Code);
- The dosage given to the client; and
- One unit of service.

Input this information in the *Comments* section of the HCFA-1500 claim form.

Synagis

Retroactive to dates of service on and after December 1, 2004, MAA changed the maximum allowable fee for Synagis:

CPT Code	Brief Description	12/1/04 Maximum Allowable Fee	Restrictions
90378	Rsv ig, im, (50mg)	$621.18 (per 50 mg)	PA is not required for clients 11-months of age and younger from December 1, 2004 through April 30, 2005. PA is required for all other time periods and for all other age groups.

Injectable Drug Maximum Allowable Fees Changes

Effective January 1, 2005, MAA will adopt Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA will continue to price the drug at 86% of the Average Wholesale Price (AWP). MAA has updated its injectable drug pricing for most drugs. These prices may be posted as often as quarterly on MAA's website at http://maa.dshs.wa.gov, click on Provider Publications/Fee Schedules, then Fee Schedules. Only those drugs with price changes are updated. All other drugs remain at MAA's last published price.

Updated Policy, Technical Changes, and Corrections

Updated Policy and Technical Changes

- **Ultraviolet Phototherapy**

  MAA does not cover ultraviolet phototherapy (CPT code 96910) when billed with diagnosis code 709.01 (Vitiligo). MAA considers this a cosmetic procedure.

- **Ultrasound Guidance**

  MAA no longer requires prior authorization (PA) for ultrasound guidance for vascular access (CPT code 76937).

- **HIV Test**

  MAA published the wrong rate for procedure code 0023T. The correct rate is $80.00. **Retroactive to dates of service on and after July 1, 2004**, MAA will reimburse for 0023T at the correct rate.

AV Fistulas and Doppler Vein Mapping

MAA inadvertently published and loaded into its system incorrect prices for AV fistulas and Doppler vein mapping. Retroactive to July 1, 2004, MAA has corrected the fees for the following procedure codes:

CPT Code	Description	7/1/04 Maximum Allowable Fee
36821	AV fistula, open, direct, any site	$539.06 (all settings)
36832	AV fistula, revision, open	$605.91 (all settings)
93970	Bilateral venous studies, complete	$183.26 (all settings)
93970-TC	Technical component	$147.72 (all settings)
93970-26	Professional component	$35.54 (all settings)
93971	Unilateral or limited venous studies	$129.89 (all settings)
93971-TC	Technical component	$106.45 (all settings)
93971-26	Professional Component	$23.44 (all settings)

Providers must submit an adjustment form to receive the higher reimbursement amount for any claims for these procedures that have already been paid.

- **Psychotherapy**

MAA limits reimbursement for psychotherapy performed by psychiatrists to 12 hours per calendar year, and reimburses providers for up to one hour per day. ***MAA reimburses the following CPT codes with ICD-9-CM diagnosis codes 290-319 only.*** MAA has changed the following CPT codes to covered status; the maximum allowable fees are set equivalent to one hour of psychotherapy. ***MAA reimburses a maximum of one psychiatric procedure code per day.***

Procedure Code	Brief Description	January 1, 2005 Maximum Allowable Fee	
		NFS Fee	FS Fee
90808	Psytx, office, 75-80 min	$59.17	$56.90
90809	Psytx, off, 75-80, w/e&m	63.02	61.44
90814*	Intac, psytx, off, 75-80 min	63.93	60.53
90815*	Intac psytx, 75-80 w/e&m	67.10	64.84
90821	Psytx, hosp, 75-80 min	59.62	59.62
90822	Psytx, hodp 75-80 min w/e&m	62.57	62.57
90828*	Intac psytx, hosp, 75-80 min	63.25	63.25
90829*	Intac psytx, hsp 75-80 w/e&m	65.97	65.97

***Codes 90814, 90815, 90828, and 90829 are limited to clients 20 years of age and younger**

- **Endoscopy**

Retroactive to October 1, 2004, the following endoscopy procedure codes have been included in the 52000 endoscopy base family per Medicare:

Procedure Code	Brief Description
52320	Cystoscopy and treatment
52325	Cystoscopy stone removal
52327	Cystoscopy, inject material
52330	Cystoscopy and treatment
52332	Cystoscopy and treatment
52334	Create passage to kidney
52341	Cysto w/ureter stricture tx
52342	Cysto w/up stricture tx
52343	Cysto w/renal stricture tx
52344	Cysto/uretero, stone remove

- **Botulinum Injections**

Botulinum injections (HCPCS codes J0585 and J0587**)** require prior authorization (PA) ***except*** when billed with one of the following diagnoses:

- ✓ 333.81 (Blepharospasm);
- ✓ 333.83 (Spasmodic Torticollis; and
- ✓ 723.5 (Torticollis, unspecified – contracture of neck).

- **Vagus Nerve Stimulation**

MAA now requires PA for Vagus Nerve Stimulation (CPT codes 61885, 64573, 61886, and 64585).

- **Blepharoplasties**

The following blepharoplasties require PA:

CPT Code	Brief Description	January 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
15822	Revision of upper eyelid	$238.72	$205.62
15823	Revision of upper eyelid	345.49	310.13

☞ **Note:** Clients age 18 years and older require prior authorization.

- **Chemotherapy**

Effective January 1, 2005, MAA will adopt Medicare's new HCPCS codes (listed below) for chemotherapy administration. However, these new codes may not be billed in addition to the current CPT codes for these procedures. Claims billed for the same date of service with both the HCPCS codes and the CPT codes ***will be denied.***

Procedure Code	CPT Crosswalk Procedure Codes	Brief Description	January 1, 2005 Maximum Allowable Fee	
			Non Facility Setting	Facility Setting
G0345	90780	IV infuse hydration, initial	$37.63	$37.63
G0346	90781	Each additional infuse hour	12.02	12.02
G0347	90780	IV infusion therapy/diagnost	46.25	46.25
G0348	90781	Each additional hr up to 8hr	15.42	15.42
G0349	90781	Additional sequential infuse	25.39	25.39
G0350	N/A	Concurrent infusion	14.74	14.74
G0351	90782	Therapeutic/diagnostic injec	11.11	11.11
G0353	90784	IV push,single orinitial dru	34.46	34.46
G0354	N/A	Each addition sequential IV	16.10	16.10
G0355	96400	Chemo adminisrate subcut/IM	31.06	31.06
G0356	96400	Hormonal anti-neoplastic	21.54	21.54
G0357	96408	IV push single/initial subst	73.45	73.45
G0358	96408	IV push each additional drug	42.62	42.62
G0359	96410	Chemotherapy IV one hr initi	103.83	103.83
G0360	96412	Each additional hr 1-8 hrs	23.35	23.35
G0361	96414	Prolong chemo infuse>8hrs pu	111.76	111.76
G0362	96412	Each add sequential infusion	50.55	50.55
G0363	N/A	Irrigate implanted venous de	17.00	17.00

Corrections

Page #	Corrections
C.10	CPT code 90645 was added to the "shaded" immunization section of the EPSDT section. It was inadvertently left out of the original billing instructions.
C.11	• MAA published an incorrect CPT code for the chicken pox vaccine. **The correct CPT code for this vaccine is 90716.** • AMA has revised the definition of CPT code 90700 to only include those individuals 7 years of age or younger. Therefore, MAA removed this code from the adult immunization section.
E.4	MAA has changed the fourth bullet of the Limitations for Inpatient and Outpatient Psychiatric Services to read: *"MAA limits psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, up to a total of 12 hours per calendar year*"
E.12	MAA has updated the diagnosis codes for procedure code G0101 to read: *"*V25-V25.3, V25.4-V25.9, and V76.2"
F.6	Under the Labor Management section, the following sentence has been updated with the correct CPT code range: *"In addition to the hospital admission, MAA reimburses providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99357 with modifier TH.**"* The **corrected** range of labor management CPT codes is: *"In addition to the hospital admission, MAA reimburses providers for **up to three hours** of labor management using prolonged services CPT **codes 99356-99357 with modifier TH.**"*
F.7	MAA changed the following sentence, regarding consultations, from the Maternity Section: *"If a follow-up consultation is necessary, bill using CPT codes 99261-99263."* The **corrected** paragraph states: *"If a follow-up **inpatient** consultation is necessary, bill using CPT codes 99261-99263."*

Page #	Corrections
F.28	MAA **deleted** the following bullet from the General Anesthesia Section: • *Do not bill CPT codes 00800-00882 or 00920-00952 for abortions, hysterectomies, or sterilization procedures. Use the appropriate CPT code.* The new bullet states the following: • *When billing the following procedures, use only the codes indicated below:* ➢ *Vasectomies: 00921;* ➢ *Hysterectomies: 00846, 00944, 01962-01963, 01969;* ➢ *Sterilizations: 00851; and* ➢ *Abortions: 01964.*
I.23	MAA has updated the MAA-Approved Sleep Centers List.

Billing Instructions Replacement Pages

Attached are replacement pages C.9-C.12, E.3-E.4, E.11-E.12, F.5-F.8, F.27-F.28, G.9-G.10, K.7-K.10, and I.23-I.24 for MAA's current *Physician-Related Services Billing Instructions*.

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

JANUARY 2005 NEW PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective January 1, 2005

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
00561		25 Base	25 Base		000	N
11004		335.74	335.74		000	N
11005		457.25	457.25		000	N
11006		420.98	420.98		000	N
11008		170.93	170.93		000	N
19296		2,962.97	124.00	PA	000	N
19297		56.90	56.90	PA	000	N
19298		1,110.38	199.27	PA	000	N
27412		945.79	945.79	PA	090	Y
27415		786.42	786.42	PA	090	Y
29866		618.66	618.66	PA	090	N
29867		739.50	739.50	PA	090	N
29868		#	#		090	N
31545		229.42	229.42		000	N
31546		349.12	349.12		000	N
31620		163.00	46.47	PA	000	N
31636		143.73	143.73		000	N
31637		51.01	51.01		000	N
31638		160.05	160.05		000	N
32019		559.95	140.10	PA	000	N
32855		B.R.	B.R.		090	Y
32856		B.R.	B.R.		090	Y
33933		B.R.	B.R.		000	Y
33944		B.R.	B.R.		000	Y
34803		815.44	815.44		090	Y
36475		#	#		000	N
36476		#	#		000	N
36478		#	#		000	N
36479		#	#		000	N
36818		434.13	434.13		090	Y
37215		653.12	653.12		090	Y
37216		629.32	629.32		090	Y
43257		181.81	181.81		000	N
43644		946.02	946.02	PA	090	Y
43645		1,019.70	1,019.70	PA	090	Y
43845		B.R.	B.R.	PA	090	Y
44137		B.R.	B.R.		000	Y
44715		B.R.	B.R.		000	Y
44720		159.60	159.60		000	Y
44721		231.46	231.46		000	Y
45391		168.44	168.44		000	N
45392		213.10	213.10		000	N
46947		193.83	193.83		090	N
47143		B.R.	B.R.		000	Y
47144		B.R.	B.R.		090	Y
47145		B.R.	B.R.		090	Y
47146		198.36	198.36		000	Y
47147		231.46	231.46		090	Y
48551		B.R.	B.R.		000	Y
48552		136.70	136.70		000	Y
50323		B.R.	B.R.		000	Y
50325		B.R.	B.R.		000	Y
50327		127.18	127.18		000	Y
50328		111.31	111.31		000	Y
50329		106.32	106.32		000	Y
50391		83.20	61.44		000	N
52402		165.94	165.94	PA	000	N
57267		167.76	167.76		000	Y
57283		400.35	400.35		090	Y
58356		316.25	220.13	PA	010	Y
58565		#	#		090	N
58956		780.75	780.75		090	Y
63050		827.23	827.23		090	Y
63051		943.98	943.98		090	Y
63295		187.03	187.03		000	Y
66711		303.78	303.78		090	N
76077		23.58	23.58		000	N
76077	26	5.44	5.44		000	N
76077	TC	18.14	18.14		000	N
76510		102.47	102.47	PA	000	N
76510	26	51.23	51.23	PA	000	N
76510	TC	51.23	51.23	PA	000	N
76820		55.31	55.31		000	N
76820	26	16.32	16.32		000	N
76820	TC	38.99	38.99		000	N
76821		61.66	61.66		000	N
76821	26	22.67	22.67		000	N
76821	TC	38.99	38.99		000	N
78811		#	#		000	N
78811	26	#	#		000	N
78811	TC	#	#		000	N
78812		#	#		000	N
78812	26	#	#		000	N
78812	TC	#	#		000	N
78813		#	#		000	N
78813	26	#	#		000	N
78813	TC	#	#		000	N
78814		1,295.82	1,295.82	PA	000	N
78814	26	52.14	52.14	PA	000	N
78814	TC	1,243.68	1,243.68	PA	000	N
78815		1,301.26	1,301.26	PA	000	N
78815	26	57.58	57.58	PA	000	N

- Not Covered
B.R. – By Report
A.C. – Acquisition Cost

PA – Written/FAX Auth
EX – Expedited Prior Auth
LE – Limitation Extension

JANUARY 2005 NEW PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective January 1, 2005

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
78815	TC	1,243.68	1,243.68	PA	000	N
78816		1,302.62	1,302.62	PA	000	N
78816	26	58.94	58.94	PA	000	N
78816	TC	1,243.68	1,243.68	PA	000	N
79005		118.79	118.79	PA	000	N
79005	26	55.99	55.99	PA	000	N
79005	TC	62.57	62.57	PA	000	N
79101		124.00	124.00	PA	000	N
79101	26	61.44	61.44	PA	000	N
79101	TC	62.57	62.57	PA	000	N
79445		138.51	138.51	PA	000	N
79445	26	75.49	75.49	PA	000	N
79445	TC	63.02	63.02	PA	000	N
82045		37.80	37.80		000	N
82656		12.85	12.85		000	N
83009		75.01	75.01		000	N
83630		12.85	12.85		000	N
84163		16.76	16.76		000	N
84166		19.40	19.40		000	N
84166	26	11.79	11.79		000	N
86064		42.00	42.00		000	N
86335		32.31	32.31		000	N
86335	26	11.79	11.79		000	N
86379		42.00	42.00		000	N
86587		42.00	42.00		000	N
87807		13.36	13.36		000	N
88184		30.60	30.60		000	N
88185		14.96	14.96		000	N
88187		41.49	41.49		000	N
88188		51.69	51.69		000	N
88189		68.01	68.01		000	N
88360		66.20	66.20		000	N
88360	26	36.95	36.95		000	N
88360	TC	29.24	29.24		000	N
88367		125.82	125.82		000	N
88367	26	43.07	43.07		000	N
88367	TC	82.97	82.97		000	N
88368		114.26	114.26		000	N
88368	26	46.70	46.70		000	N
88368	TC	67.56	67.56		000	N
90465		11.11	11.11		000	N
90466		6.57	6.57		000	N
90467		5.00	5.00		000	N
90468		3.00	3.00		000	N
91034		144.41	144.41		000	N
91034	26	30.83	30.83		000	N
91034	TC	113.35	113.35		000	N
91035		285.87	285.87		000	N
91035	26	50.10	50.10		000	N
91035	TC	235.77	235.77		000	N
91037		91.36	91.36		000	N
91037	26	30.83	30.83		000	N
91037	TC	60.53	60.53		000	N
91038		77.98	77.98		000	N
91038	26	34.91	34.91		000	N
91038	TC	43.07	43.07		000	N
91040		279.29	279.29		000	N
91040	26	30.83	30.83		000	N
91040	TC	248.46	248.46		000	N
91120		275.67	275.67		000	N
91120	26	31.06	31.06		000	N
91120	TC	244.61	244.61		000	N
92620		27.20	27.20		000	N
92621		6.80	6.80		000	N
92625		26.75	26.75		000	N
93745		B.R.	B.R.	PA	000	N
93745	26	B.R.	B.R.	PA	000	N
93745	TC	B.R.	B.R.	PA	000	N
93890		143.27	143.27		000	N
93890	26	32.87	32.87		000	N
93890	TC	110.18	110.18		000	N
93892		152.57	152.57		000	N
93892	26	37.86	37.86		000	N
93892	TC	114.71	114.71		000	N
93893		149.62	149.62		000	N
93893	26	37.86	37.86		000	N
93893	TC	111.76	111.76		000	N
94452		#	#		000	N
94452	26	#	#		000	N
94452	TC	#	#		000	N
94453		#	#		000	N
94453	26	#	#		000	N
94453	TC	#	#		000	N
95928		104.96	104.96		000	N
95928	26	50.10	50.10		000	N
95928	TC	54.86	54.86		000	N
95929		109.27	109.27		000	N
95929	26	50.10	50.10		000	N
95929	TC	59.17	59.17		000	N
95978		126.95	112.67		000	N
95979		58.72	54.63		000	N
97597		29.24	29.24		000	N

JANUARY 2005 NEW PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective January 1, 2005

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
97598		37.18	37.18		000	N
97605		Bundled	Bundled		000	N
97606		Bundled	Bundled		000	N
97810		#	#		000	N
97811		#	#		000	N
97813		#	#		000	N
97814		#	#		000	N
0075T		B.R.	B.R.		000	N
0076T		B.R.	B.R.		000	N
0077T		B.R.	B.R.	PA	000	N
0078T		B.R.	B.R.	PA	000	N
0079T		B.R.	B.R.	PA	000	N
0080T		B.R.	B.R.	PA	000	N
0081T		B.R.	B.R.	PA	000	N
0082T		B.R.	B.R.	PA	000	N
0083T		B.R.	B.R.	PA	000	N
0084T		#	#		000	N
0085T		B.R.	B.R.	PA	000	N
0086T		B.R.	B.R.	PA	000	N
0087T		#	#		000	N
0088T		#	#		000	N
A9180		#	#		000	N
G0336		#	#		000	N
G0337		#	#		000	N
G0341		#	#		000	N
G0342		#	#		000	N
G0343		#	#		000	N
G0344		#	#		000	N
G0345		37.63	37.63		000	N
G0346		12.02	12.02		000	N
G0347		46.25	46.25		000	N
G0348		15.42	15.42		000	N
G0349		25.39	25.39		000	N
G0350		14.74	14.74		000	N
G0351		11.11	11.11		000	N
G0353		34.46	34.46		000	N
G0354		16.10	16.10		000	N
G0355		31.06	31.06		000	N
G0356		21.54	21.54		000	N
G0357		73.45	73.45		000	N
G0358		42.62	42.62		000	N
G0359		103.83	103.83		000	N
G0360		23.35	23.35		000	N
G0361		111.76	111.76		000	N
G0362		50.55	50.55		000	N
G0363		17.00	17.00		000	N
G0364		#	#		000	N
G0365		#	#		000	N
G0365	26	#	#		000	N
G0365	TC	#	#		000	N
G0366		#	#		000	N
G0367		#	#		000	N
G0368		#	#		000	N
G0369		#	#		000	N
G0370		#	#		000	N
G0371		#	#		000	N
G0374		#	#		000	N
G9013		#	#		000	N
G9014		#	#		000	N
G9017		#	#		000	N
G9018		#	#		000	N
G9019		#	#		000	N
G9020		#	#		000	N
G9021		#	#		000	N
G9022		#	#		000	N
G9023		#	#		000	N
G9024		#	#		000	N
G9025		#	#		000	N
G9026		#	#		000	N
G9027		#	#		000	N
G9028		#	#		000	N
G9029		#	#		000	N
G9030		#	#		000	N
G9031		#	#		000	N
G9032		#	#		000	N
G9034		#	#		000	N
G9035		#	#		000	N
G9036		#	#		000	N
G9037		#	#		000	N
J0128		68.62	68.62		000	N
J0135		577.56	577.56		000	N
J0180		121.12	121.12		000	N
J0878		0.28	0.28		000	N
J1457		1.25	1.25		000	N
J1931		22.74	22.74	PA	000	N
J2357		15.32	15.32	PA	000	N
J2469		18.22	18.22		000	N
J2794		4.60	4.60		000	N
J3110		6.99	6.99		000	N
J3246		7.85	7.85		000	N
J3396		8.99	8.99		000	N
J7343		6.60	6.60	PA	000	N

- Not Covered
B.R. – By Report
A.C. – Acquisition Cost

PA – Written/FAX Auth
EX – Expedited Prior Auth
LE – Limitation Extension

JANUARY 2005 NEW PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective January 1, 2005

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
J7344		59.63	59.63	PA	000	N
J7518		#	#		000	N
J7611		0.05	0.05		000	N
J7612		0.87	0.87		000	N
J7613		0.07	0.07		000	N
J7614		1.28	1.28		000	N
J7616		2.60	2.60		000	N
J7617		A.C.	A.C.		000	N
J7674		#	#		000	N
J8501		#	#		000	N
J8565		#	#		000	N
J9035		57.08	57.08		000	N
J9041		28.38	28.38		000	N
J9055		49.64	49.64		000	N
J9305		40.54	40.54		000	N
Q4054		3.54	3.54			
Q4055		9.76	9.76		000	N
S0109		#	#		000	N
S0116		A.C.	A.C.	PA	000	N
S0117		#	#		000	N
S0158		A.C.	A.C.	PA	000	N
S0159		A.C.	A.C.	PA	000	N
S0160		#	#		000	N
S0161		#	#		000	N
S0162		A.C.	A.C.	PA	000	N
S0164		#	#		000	N
S0166		#	#		000	N
S0167		#	#		000	N
S0168		#	#		000	N
S0194		#	#		000	N
S0196		#	#		000	N
S0257		#	#		000	N
S0515		#	#		000	N
S0618		#	#		000	N
S2082		B.R.	B.R.	PA	000	N
S2083		B.R.	B.R.	PA	000	N
S2152		B.R.	B.R.		000	N
S2215		#	#		000	N
S2348		#	#		000	N
S4042		#	#		000	N
S8093		#	#		000	N
S9097		#	#		000	N
S9482		#	#		000	N
S9988		#	#		000	N

Clients age 18 years and younger – Vaccines that are identified by shading

- These vaccines are available at no cost from DOH. Therefore, MAA reimburses providers for an administration fee only.
- Bill for the administration of the vaccine by reporting the procedure code given with modifier SL (e.g. 90707 SL).
- DO NOT bill CPT codes 90471 or 90472 for the administration of the vaccine.

Clients age 18 years and younger – Vaccines not identified by shading

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with non-shaded vaccines. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Clients age 19-20 years – All Vaccines

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is shaded or not. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Note: Only Health Departments may bill CPT code 99211 when an immunization is the only service provided.

Vaccines that are shaded in the table are available at no cost from DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children age 18 years and younger.
MAA does not reimburse providers for these vaccines.

CPT	Vaccine
90585	Bcg vaccine, percut
90586	Bcg vaccine, intravescial
90632	Hep a vaccine, adult im
90633	Hep a vacc, ped/adol, 2 dose
90636	Hep a/Hep B vacc (adult)
90645	Hib vaccine, hboc, im
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90655	Flu vacc split pres free 6-35 months
90656	Flu vacc split pres free 3 years and above
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90659	Flu vaccine, whole, im
90660	Flu vacc, nasal
90665	Lyme disease vaccine, im
90669	Pneumococcal vacc, ped<5
90675	Rabies vaccine, im
90676	Rabies vaccine, id
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90700	Dtap vaccine, im
90701	Dtp vaccine, im
90702	Dt vaccine <7, im
90703	Tetanus vaccine, im
90704	Mumps vaccine, sc
90705	Measles vaccine, sc
90706	Rubella vaccine, sc
90707	Mmr vaccine, sc
90708	Measles-rubella vaccine, sc
90709	Rubella & mumpsvaccine, sc
90712	Oral poliovirus vaccine
90713	Poliovirus, ipv, sc
90715	TdaP, 7 years and older, intramuscular
90716	Chicken pox vaccine, sc
90717	Yellow fever vaccine, sc
90718	Td vaccine >7, im
90720	Dtp/hib vaccine, im
90725	Cholera vaccine, injectable
90732	Pneumoccocal vacc, adult/ill ***(requires prior authorization)***
90733	Meningococcal vaccine, sc
90734	Meningococcal vacc, intramuscular *(requires prior authorization)*
90735	Encephalitis, vaccine, sc
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hep b vacc ped/adol 3 dose, im
90746	Hep b vaccine, adult, im
90747	Hep b vacc, ill pat 4 dose, im
90748	Hep b/hib vaccine, im
90749	Vaccine toxoid

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children" on page C.8.)

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, precut	90707	Mmr vaccine, sc
90586	Bcg vaccine, intravesical	90708	Measles-rubella vaccine, sc
90632	Hep a vaccine, adult im	90709	Rubella & mumps vaccine, sc
90636	Hep a/hep b vacc, adult im	90712	Oral poliovirus vaccine
90645	Hib vaccine, hboc, im	90713	Poliovirus, ipv, sc
90646	Hib vaccine, prp-d, im	90715	TdaP, 7 years and older, Intramuscular
90647	Hib vaccine, prp-omp, im	90716	Chicken pox vaccine, sc
90648	Hib vaccine, prp-t, im	90717	Yellow fever vaccine, sc
90656	Flu vacc split pres free 3 years and above	90718	Td vaccine >7, im
90658	Flu vaccine, 3 yrs, im	90720	Dtp/hib vaccine, im
90660	Flu vacc, nasal	90725	Cholera vaccine, injectable
90665	Lyme disease vaccine, im	90732	Pneumococcal vacc, adult/ill ***(requires prior authorization)***
90675	Rabies vaccine, im	90733	Meningococcal vaccine, sc
90676	Rabies vaccine, id	90734	Meningococcal vacc, intramuscular ***(requires prior authorization)***
90690	Typhoid vaccine, oral	90735	Encephalitis vaccine, sc
90691	Typhoid vaccine, im	90740	Hepb vacc, ill pat 3 dose, im
90692	Typhoid vaccine, h-p, sc/id	90746	Hep b vaccine, adult, im
90701	Dtp vaccine, im	90747	Hepb vacc, ill pat 4 dose, im
90703	Teanus vaccine, im	90748	Hep b/hib vaccine, im
90704	Mumps vaccine, sc	90749	Vaccine toxoid
90706	Rubella vaccine, sc		

Immune Globulins

> ☞ **Note:** MAA does not reimburse immune globulins that are obtained free of charge.

- **RespiGam** – Do not bill CPT code 90379 for RespiGam. You must use HCPCS code J1565.

- **Synagis** (CPT code 90378)

  ✓ Bill one unit for each 50 mg of Synagis used.

  ✓ MAA covers Synagis for those clients 11 months of age and younger from December 1 - April 30 of any given year without prior authorization (PA).

  ✓ PA is required for all other time periods and for all other age groups.

  Requests for authorization must be submitted in writing to:

  MAA-Division of Medical Management
  Attn: Synagis Program
  PO Box 45506
  Olympia, WA 98504-5506
  FAX: (360) 725-2141

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1 ml syringes used. Bill each 1 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

Inpatient Hospital

Inpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90816-90822, , 90823-90829*, 90845, 90847, 90853-90871, 90899	Any MAA covered diagnosis code in the following range: **ICD-9-CM 290-319**
Inpatient	
99217-99239	All MAA covered diagnosis codes
Inpatient Consultation	
99251-99275	All MAA covered diagnosis codes
Case Management	
99371-99373	All MAA covered diagnosis codes

*Codes 90823-90829 are limited to clients 20 years of age and younger.

All inpatient psychiatric services must be coordinated by either the local RSN or the client's MAA managed care plan.

Outpatient Hospital

Outpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90804- 90809, 90810- 90815*, 90845, 90847, 90853-90871, 90899 The above procedure codes (except 90862) are subject to a limit of 12 hours per client, per calendar year.	Any MAA covered diagnosis code in the following range: **ICD-9-CM 290-319**
Outpatient	
99201-99215	Any MAA covered diagnosis codes except **ICD-9-CM 290-319**
Outpatient Consultation	
99241-99245	Any MAA covered diagnosis codes except **ICD-9-CM 290-319**
Emergency Room Consultation	
99281-99285	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Nursing Facility Services	
99301-99316	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Domiciliary/Rest Home Services	
99321-99333	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Standby Services	
99360	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Case Management Services	
99371-99373	All MAA covered diagnosis codes

* Codes 90810- 90815 are limited to clients 20 years of age and younger.

Any other outpatient psychiatric services must be coordinated by either the local RSN or the client's MAA managed care plan.

Limitations for Inpatient and Outpatient Psychiatric Services:

- MAA does not reimburse the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and the diagnoses are completely unrelated.

- MAA reimburses psychiatrists and psychiatric ARNPs for only those procedure codes and diagnosis codes that are within their scope of practice.

- MAA reimburses psychiatric ARNPs for the following psychiatric services only:

  - ✓ 90801 - Psychiatric Diagnostic Interview Examination;
  - ✓ 90802 - Interactive Psychiatric Diagnostic Interview Examination; and
  - ✓ 90862 - Pharmacological management.

- MAA limits psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy.

- Family therapy is covered only when the client is present.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year unless a change in the client's condition occurs resulting in a new mental health diagnosis.

- Outpatient psychiatric services are not allowed for clients on the General Assistance Unemployable (GAU) program, except for medication adjustment (CPT code 90862). GAU clients must seek psychiatric services through their local Community Mental Health Center.

- Individual psychotherapy, interactive services (CPT codes 90810-90813 and 90823-90827) may be billed only for clients age 20 and younger.

Consultation on X-Ray Examination

When billing a consultation, the consulting physician must bill the specific x-ray code with modifier 26 (professional component).

For example: The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT code 71020-26), and the consulting physician would bill only for the professional component of the chest x-ray (e.g., CPT code 71020-26).

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility are limited to the following tests:

  ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  ✓ Chest or abdominal films that do not involve the use of contrast media; or
  ✓ Diagnostic mammograms.

- To bill for transportation of equipment, bill either HCPCS code R0070 (one patient, one unit) or HCPCS code R0075 (multiple patients, multiple units).

☞ **Note:** MAA's reimbursement for R0070 and R0075 includes setup.

Heart Catheterizations

When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), MAA reimburses providers for the appropriate **procedure code with modifier 26 (professional component) only**. To bill using either the global or technical components, providers must have a contract with MAA certifying they perform heart catheterizations in their office and that they own their own equipment.

Use cardiac catheterization and angiography to report services individually. It is not appropriate to bill with modifier 51 (multiple procedures) with any of these codes.

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid.

MAA reimburses laboratories for Medicare-approved tests only.

CLIA Certification

All facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with MAA in order to receive reimbursement from MAA.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2805 or write to:

Department of Health
Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, Washington 98155
(206) 361-2805
(206) 361-2813 FAX

Reference Laboratory

If a laboratory sends a specimen to a reference (outside) lab, you may bill for the reference lab. However, the reference lab provider number must be entered in the performing provider number field. The reference lab must be CLIA-certified and have an active CLIA identification number on file with MAA. Use modifier 90.

Cancer Screens (HCPCS codes G0101-G0107 and G0120-G0122)

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0101	Females only *[Use for Pap smear professional services]*	V25.01 through V25.2, V25.40 through V25.9, and V76.2
G0102	Bundled	N/A
G0103	Males age 50 and older Once every 12 months	Any valid ICD-9-CM code other than high risk

Additional Monitoring for High-Risk Conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. ***The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.*** **For example:**

> Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. *It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.*

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for the hospital admission or for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and admitted the client to the hospital during labor, but another provider (outside of your group practice) takes over delivery, you must unbundle the global OB package and bill separately for antepartum care, the hospital admission, and the time spent managing the client's labor. The client must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill MAA for one of the hospital admission CPT **codes 99221-99223 with modifier TH**. In addition to the hospital admission, MAA reimburses providers for **up to three hours** of labor management using prolonged services CPT **codes 99356-99357 with modifier TH**. Reimbursement for prolonged services is *limited to three hours per client, per pregnancy*, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

☞ **Note**: The hospital admission code and the prolonged services code(s) **must** be billed on the same claim form.

High-Risk Deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, MAA reimburses providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG).

Modifier TG: Complex/high level of care

The ICD-9-CM diagnosis code ***must clearly*** demonstrate the medical necessity for the high-risk delivery add-on (e.g. a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the mother had a high-risk condition during the antepartum period.

Bill only *ONE* line of service (e.g. 59400 TG) to receive reimbursement for BOTH the delivery and the high-risk add-on. *DO NOT* bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.

A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99440, when appropriate.

☞ **Note:** MAA **does not** reimburse an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Reimbursement is limited to one per client, per pregnancy (even in the case of multiple births).

Consultations

If another provider refers a client during her pregnancy for a consultation, bill MAA using consultation CPT codes 99241-99255. If a follow-up inpatient consultation is necessary, bill using CPT codes 99261-99263. You **must** list the referring physician's name and MAA-assigned provider number in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), MAA reimburses the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill MAA the appropriate consultation code.

- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill MAA the appropriate **consultation code with modifier 57** (e.g. 99241-57).

MAA does not reimburse the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** MAA for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. You must demonstrate the medical necessity (i.e. sign, symptom, or condition). MAA does not reimburse providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

MAA reimburses consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General Obstetrical Payment Policies and Limitations

- MAA reimburses a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Reimbursement for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.

- MAA reimburses for multiple births by cesarean delivery at 100% for the first baby. No additional reimbursement will be made for additional babies.

- An assistant surgeon may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Reimbursement is 20% of the delivery-only code's maximum allowance.

- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's provider number.

- RNFAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.

- To bill for anesthesia during delivery, see the Anesthesia Section (page F.26).

- For deliveries in a birthing center, refer to MAA's *Births in Birthing Centers Billing Instructions*. For deliveries in a home birth setting, refer to MAA's *Planned Home Births Billing Instructions.*

☞ **Note**: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, call MAA's Family Services Section at (360) 725-1655.

For your convenience, a table summarizing "Billing MAA for Maternity Services" is included on the following pages.

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- MAA requires providers to use anesthesia CPT codes 00100-01999 to bill for anesthesia services paid with base and time units. Providers **must not use** the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- MAA reimburses for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- MAA reimburses providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with MAA to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform are done by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post-anesthesia care.

- In addition, the anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the client within the blocks of time. Examples of this include, but are not limited to: time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e. when the client can be safely placed under postoperative supervision).

- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. MAA has assigned flat fees for these codes.

- MAA allows the following two anesthesia codes published in the American Society of Anesthesiology (ASA) Relative Value Guide (RVG):

ASA Code	Description
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections-patient in the prone position (when block or injection is performed by a different provider)

  Use these ASA codes only when a provider, other than the one performing the block or the injection, administers anesthesia.

- MAA does not adopt any other ASA RVG codes that are not included in the CPT book. Bill all other anesthesia codes according to the descriptions published in the CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, MAA follows CPT code descriptions.

- MAA does not reimburse providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. **Continue to use the appropriate anesthesia modifier with anesthesia CPT and ASA codes.**

***Exception*:** Anesthesia providers may bill CPT Pain Management/Other Services procedure codes that are not paid with base and time units. These services are reimbursed as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing anesthesia for surgical abortions (CPT code 01964), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- When billing the following procedures, use only the codes indicated below:

  ✓ Vasectomies: 00921;
  ✓ Hysterectomies: 00846, 00944, 01962-01963, 01969;
  ✓ Sterilizations: 00851; and
  ✓ Abortions: 01964.

Cochlear Implant Services [Refer to WAC 388-531-0200(4)(c)]

- Cochlear implantation (CPT code 69930) requires prior authorization (refer to Section I – Prior Authorization). Providers must send in medical documentation to justify the need for cochlear implants. In particular, MAA requires information on how the client was counseled on the different options for dealing with hearing loss such as, but not limited to, manual language.

- MAA reimburses providers for replacement parts for cochlear implants given directly to the client using HCPCS code A9900. Prior authorization is required for the replacement parts. Pricing is determined by the authorization section.

- When reimbursing for battery packs, MAA covers the **least costly, equally effective** product.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

- Vagus nerve stimulation (CPT codes 61885, 61886, 64573, and 64585) requires prior authorization (refer to Section I - Prior Authorization).

- VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.

- Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

Osseointegrated Implants

- Insertion of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).

- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

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MAA-Approved Sleep Centers

[Refer to WAC 388-531-1500]

MAA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Diagnostic Sleep Disorder Program Center	Children's Hospital and Medical - Seattle, WA
Eastside Sleep Disorder Clinic	Overlake Hospital Medical Center - Bellevue, WA
Highline Sleep Disorders Center	Highline Community Hospital - Seatttle, WA
Holy Family Sleep Disorder Center	Holy Family Hospital -Spokane, WA
Kathryn Severyns Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
Multi Care Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital - Tacoma, WA
Olympic Medical Center—Sleep Center	Olympic Medical Center Port Angeles, WA
Providence Everett Sleep Disorder Center	Providence Everett Medical Center - Everett, WA.
Richland Sleep Lab/Center/Dr. Pat Hamner	Richland Sleep Center – Richland, WA
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorders Center Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center of Harrison Hospital	Harrison Hospital - Bremerton, WA
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Related Breathing Disorders Laboratory St Clare Hospital	St. Clare Hospital - Tacoma, WA
Sleep Studies Laboratory Mid Columbia Medical Center	Mid Columbia Medical Center - Dalles, OR
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5th Suite 400 W - Spokane, WA
University of Washington Sleep Disorders Center\Harborview Medical Center	Harborview Medical Center - Seattle, WA
Valley Medical Center--Sleep Center	Valley Medical Center Renton, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.

- Enter the location of the approved sleep center where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of MAA-approved sleep center.) Enter the information into the *Comments* section of the claim form.

> ☞ **Note**: All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57,** or Narcolepsy **347**.

MAA-Approved Inpatient Pain Clinics

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

Injectable Drug Codes

MAA's fees for injectable drug codes are the maximum allowances used to reimburse covered drugs and biologicals administered in a provider's office. MAA follows Medicare's payment policy to set the maximum allowances.

Effective for dates of service on and after January 1, 2005, MAA adopted Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA prices the drug at 86% of the Average Wholesale Price (AWP). MAA obtains the AWP for these drugs from Medicare's Single Drug Pricer (SDP). MAA updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the MAA effective dates are based on dates of service, not the date the claim is received. For HCPCS codes where Medicare does not establish a rate, MAA determines the maximum allowances for covered drugs using the following methodology:

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the median AWP of all of the generic forms of the drug or biological, or the lowest brand name product AWP, whichever is less. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP according to #1 and #2 above, MAA multiplies the amount by 0.86 to arrive at the fee schedule maximum allowance.

When billing for injectable drugs and biologicals, providers must use the description of the procedure code to determine the units, and include the correct number of units on the claim form to be reimbursed the appropriate amount. For drugs priced at "acquisition cost," providers must:

- Include a copy of the manufacturer's invoice for each line item in which **billed charges** exceed $1,100.00; or
- Retain a copy of the manufacturer's invoice in the client's record for each line item in which **billed charges** are equal to or less than $1,100.00.

Do not bill using unclassified or unspecified drug codes unless there is no specific code for the drug being administered. The National Drug Code (NDC) and dosage given to the client must be included with the unclassified or unspecified drug code for coverage and payment consideration.

HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. The injectable drugs can be billed only from the provider's office supply. The name, strength, and dosage of the drug must be documented and retained in the client's record.

Chemotherapy Drug (J9000-J9999)

- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the client, the correct number of units is five (5).
- Claims with HCPCS code J9999 must include the NDC and the amount of the drug administered to the client in the *Comments* section of the claim form, and must be billed with one unit only.
- Effective for dates of service on and after January 1, 2005, MAA will adopt Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA will continue to price the drug at 86% of the Average Wholesale Price (AWP).

All Other Drugs

- Bill number of units used based on the description of the drug code. For example, if 20 mg of Hyalgan (J7316) is given to the client, the correct number of units is four (4).
- Claims with HCPCS code J3490 must include the NDC and the amount of the drug administered to the client in the *Comments* section of the claim form, and must be billed with one unit only.
- Effective for dates of service on and after January 1, 2005, MAA will adopt Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA will continue to price the drug at 86% of the Average Wholesale Price (AWP).

Prior Authorization

Drugs requiring written/fax prior authorization are noted in the fee schedule with a "PA" next to them. For information on how to request prior authorization, refer to Section I.

Rounding of Units

The following guidelines should be used to round the dosage given to the client to the appropriate number of units for billing purposes:

I. Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, MAA reimburses providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy and two 100 mg single dose vials are used to obtain the total dosage, the total of the two 100 mg vials is reimbursed. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If MAA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

II. Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, MAA reimburses providers for only the amount of drug administered to the client. **For example:**

> If a total of 750 mg of Cytarabine is required for the therapy and is taken from a 2,000 mg multi-dose vial, only the 750 mg administered to the client is reimbursed. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If MAA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

III. Unlisted Drugs (J3490 and J9999)

When it is necessary to bill MAA for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. MAA uses the NDC when unlisted drug codes are billed to appropriately price the claim. Claims must include:

- The dosage (amount) of the drug administered to the client; and
- The 11-digit NDC of the office-administered drug.

> ☞ **Note:** Bill only one unit of service

For claims billed using a paper HCFA-1500 claim form, list the required information in field 19 of the claim form.

For claims billed using an electronic HCFA-1500 claim form, list the required information in the *Comments* section of the claim form.

For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the "*Comment*" section of the claim form.

☞ **Note**: If there is an assigned HCPCS code for the administered drug, providers **must bill** MAA using the appropriate HCPCS code. ***DO NOT*** bill using an unlisted drug code for a drug that has an assigned HCPCS code. MAA will recoup payment for drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

The list of all injectable drug codes and maximum allowable fees are listed in the fee schedule section (Section J).